Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $9,061.67 for date of service, 11/07/01.

   b. The request was received on 03/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial Submission of TWCC-60
      1. HCFA 1500
      2. EOB(s)
   b. Additional documentation requested on 07/11/02 and received on 07/25/02
      1. Position statement
      2. Operative Report
      3. State Office of Administrative Hearings dated 09/05/01
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. Medical Records
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/31/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/01/02. The response from the insurance carrier was received in the Division on 08/13/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of additional information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 07/16/02

"We billed our procedure under CPT Code 37799 (unlisted vascular) since there was no specific code to reflect his operative contribution in the treatment of disease of the spinal column. The reimbursement on this code has varied; we have appealed inappropriately low payments…. Therefore, we request reconsideration for payment for the services performed. He feels that his skills result in an uncomplicated operative procedure, with minimal blood loss, few complications either immediate or remote, and a short hospital stay. These are consistent with the goals and mandate of the Workers Compensation Fund providing effective, definitive therapy, for the injured spine and returning the patient to a maximally functional status."

2. Respondent: Letter dated 08/13/02

"Dr… part in this surgery per his letter of July 16, 2002 as well as the operative report consisted of 'Anterior extraperitoneal exposure of vertebral bodies, L3-4, L4-5'. In other words, his portion of this surgery consisted of the approach or clearing of the way for the orthopedic surgeon to perform the arthrodesis. Per the Surgery Ground Rules of the Texas Workers' Compensation Commission Medical Fee Guideline 1996, page 65, E. Miscellaneous Surgical Issues, 2. **Arthrodesis**: (d) 'When anterior arthrodesis approach is performed by a different surgeon, both surgeons bill using the anterior arthrodesis CPT code with modifier –65'…. Rather than following the Surgery Ground Rules as stated and required in the Medical Fee Guideline, Dr…, alleging special skills, etc, billed under CPT Code 37799 which requires Documentation of Procedure and has no Maximum Allowable Reimbursement listed in the Medical Fee Guideline. It is the Carrier's position that in devising the 1996 Medical Fee Guideline, the Commission considered the skills necessary for a surgeon to perform a 'anterior arthrodesis approach' and that the reimbursement provided for under E, Miscellaneous Surgical Issues, 2. Arthrodesis: (d) provided the appropriate reimbursement level for this procedure…. It is the Carrier's position that Dr… is entitled to only the reimbursement provided by the requirements and dictates of the 1996 Medical Fee Guideline as set out in the Surgery Ground Rules."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/07/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $12,000.00 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $0.00 for services rendered on the date of service in dispute above and denied as "1 - R – Extent of injury/These services are not reviewable under Workers' Compensation program.." and "123 – Documentation does not support use of an unlisted procedure code."

5. The Carrier's has filed a TWCC 21 stating, "ON THE JOB INJURY OF ___ IS TO THE LOW BACK ONLY, ANY OTHER INJRIES [sic] NOT PART OF THE ON THE JOB INJURY AND OR AN ORDINARY DISEASE OF LIFE. FORE [sic] NOT COMPENSABLE." No Benefit Review Conference has been scheduled as of this date.

6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
11/07/01	37799 62	$8,500.00	$0.00	R,123	DOP	MFG; SGR (I) (3): 62 Modifier; CPT Descriptor	"**Two Surgeons:** Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. In these circumstances, add the modifier "-62" to the procedure code used for reporting services by each surgeon. DOP is required." Medical documentation indicates that the services performed were by a second surgeon, not a co-surgeon, who specializes in vascular surgeries and not orthopedic surgeries. The Requestor has provided medical documentation to support services billed in accordance with the MFG. Therefore, reimbursement **is** recommended in the amount of **$6,861.67** as listed in the Table of Disputed Services.
11/07/01	37799 51	$3,500.00	$0.00	R,123	DOP	MFG; SGR (I) (3): 51 Modifier; CPT Descriptor	**"Multiple Procedures:** When multiple procedures are performed on the same day or at the same operative session, the major procedure or service is billed as listed. For the secondary additional, or lesser procedure(s) or service(s), add modifier-51." The Requestor has provided medical documentation to support services billed in accordance with the MFG. Therefore, reimbursement **is** recommended in the amount of **$2,200.00** as listed in the Table of Disputed Services.
Totals		$12,000.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$9,061.67**.

The above Findings and Decision are hereby issued this 9th day of October 2002.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$9,061.67** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 9th day of October 2002.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division - Waco

CO/dt